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NUTRITION CONNECTION

# NUTRITION CARE PLAN REQUIRES PLANNING FOR SUCCESS

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**NUTRITION CARE PLANS ARE A VITAL PART** of the overall care plan for a resident or patient, and should function as a living document for members of the healthcare team to deliver person-centered "best practice" care. It is the care plan process that provides communication for nutrition care between residents or patients and members of the interdisciplinary team (IDT). It provides a central focus on the agreed-upon healthcare interventions, goals, and outcomes for an individual.

While it seems to be a simple concept, successful care plans require clear communication, processes, and ongoing efforts focused on specific client goals. Challenges in writing and implementing successful care plans are common in all healthcare settings. The Centers for Medicare & Medicaid Services (CMS) survey citations as of November 6, 2022 in long-term care, acute care, and home health ranked care plan development and implementation in the top 20 areas of noncompliance.

Many times, confusion is created regarding specific roles and responsibilities for the nutrition care plan. Is it the Registered Dietitian Nutritionist (RDN), the Dietetic Technician, Registered (DTR), or the Certified Dietary Manager, Certified Food Protection Professional (CDM, CFPP) that has responsibility? How does Food and Nutrition Services work with the interdisciplinary team in care plan development and implementation?

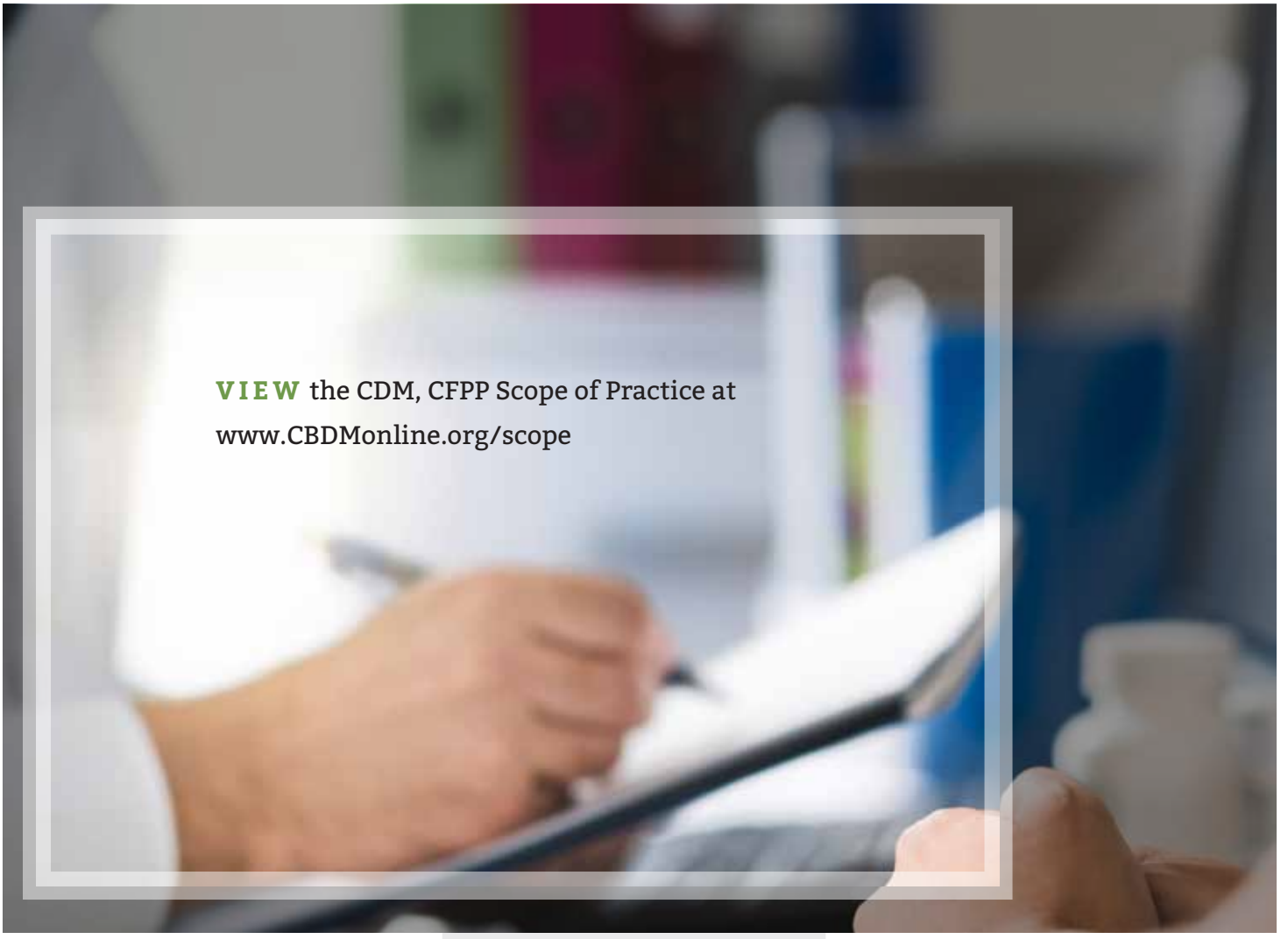
This article will present some regulatory background information and guidance on the care plan and care plan processes. While the majority of information is focused on requirements in the long-term care setting, the intent is that each healthcare setting will review their current nutrition care planning processes with a focus on continuous improvement.

## REGULATORY REQUIREMENTS AND GUIDANCE FOR CARE PLANS

The CMS State Operations Manual (SOM) for Long Term Care revised 10/21/22 includes regulatory language, with guidance to surveyors on the overall care plan purpose, components of the care plan, and how to determine compliance of development and implementation of the person-centered care plan. It's interesting that if a search for the term "care plan" is conducted for this manual, the term is included 670 times throughout the document.

Comprehensive person-centered care planning in long-term care includes development and implementation of a baseline plan of care for each resident that includes the instructions needed to provide effective and person-centered care for the resident that meet professional standards of quality. The baseline care plan must be developed within 48 hours of a resident's admission and must include the minimum healthcare information necessary to properly care for a resident including, but not limited to:

- Initial goals based on admission orders
- Physician and dietary orders
- Therapy and social services




- Preadmission Screening and Resident Review (PASRR), if applicable. (PASRR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes.)

Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission.

The facility must also develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The services provided or arranged by the facility, as outlined in the comprehensive care plan, must be

**CULTURALLY-COMPETENT AND TRAUMA-INFORMED.**

The comprehensive care plan must describe the following:

- Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being requirements;
- Services that would otherwise be required but are not provided due to the resident's exercise of rights to include the right to refuse treatment;
- Specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASRR recommendations; and
- In consultation with the resident and the resident's representative(s), the resident's goals for admission and desired outcomes and preference and potential for future discharge. (Discharge plans as appropriate)

**REFERENCES**
Scan QR code to view the list of resources for this article.

The services provided or arranged by the facility, as outlined in the comprehensive care plan, must be culturally-competent and trauma-informed. "Culture" is the conceptual system that structures the way people view the world. It is the particular set of beliefs, norms, and values that influence ideas about the nature of relationships, the way people live their lives, and the way people organize their world.

"Trauma-informed care" is an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures, and practices to avoid re-traumatization. Interventions for trauma survivors should recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, aggression, depression, anxiety, and withdrawal or isolation from others.

The overall intent is that each resident will have a person-centered comprehensive care plan developed and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. "Person-centered care" means to focus on the resident as the locus of control and support him or her in making their own choices and having control over their daily lives.

The comprehensive care plan can take the place of the baseline care plan if the comprehensive plan is developed within 48 hours of the resident's admission and meets the requirements.

When developing the comprehensive care plan in long-term care, facility staff must follow the process outlined in the CMS Resident Assessment Instrument (RAI) Manual and, at a minimum, use the Minimum Data Set (MDS) to assess the resident's clinical condition, cognitive and functional status, and use of services.

The RAI Manual is available on the CMS website and provides comprehensive discussion on the overall resident assessment and care planning process. This manual, while specific to long-term care, offers information that can be used in all settings as a resource to review current care planning processes.

## COMPLIANCE WITH CARE PLANNING

Regulatory compliance involves surveyor's investigation and determination based on whether or not the care plan:

- Is comprehensive and individualized;
- Meets each of the medical, nursing, mental, and psychosocial needs identified on the resident's comprehensive assessment;
- Includes measurable objectives, interventions, and time frames for how staff will meet the resident's needs; and
- Describes all of the following:
  - Resident goals and desired outcomes;
  - The care/services to be furnished so the resident can attain or maintain his/her highest practicable physical, mental, and psychosocial well-being;
  - The specialized services to be provided as a result of the PASRR evaluation and/or the comprehensive assessment;
  - The resident's discharge plan and any referrals to the local contact agency;
  - Refusals of care and action taken by facility staff to educate the resident and resident representative, if applicable, regarding alternatives and consequences; and
  - Care and services which are culturally-competent and trauma-informed.

## DEFINING THE CARE PLAN TEAM

It is important to select care plan team members and assign responsibility and accountability. Interdisciplinary teams (IDT) in care planning mean that professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident. The mechanics of how the IDT meets its responsibilities in developing an interdisciplinary care plan (e.g., a face-to-face meeting, teleconference, written communication) is at the discretion of the facility. It is important to remember that written communication in the medical record must reflect involvement of the resident and resident representative, if applicable, and other members of the IDT as appropriate.

In long-term care the IDT must, at a minimum, consist of the resident's attending physician or NPP (non-physician practitioner) delegate who is involved in the resident's care and is permitted by law, a registered nurse and nurse aide with responsibility for the resident, a member of the food and nutrition services staff, and to the extent possible, the resident and resident representative.

## ADDITIONAL CONSIDERATIONS FOR SUCCESSFUL NUTRITION CARE PLANS

### Nutrition Care Plan Team: Clarify Roles and Responsibilities

- Review Scope of Practice of the RDN, DTR, and CDM, CFPP. The Scopes of Practice for RDNs and for DTRs are available from the Academy of Nutrition and Dietetics, and the Scope of Practice for CDM, CFPPs is available on the Certifying Board for Dietary Managers website.
- Review state licensure of RDNs (if applicable).
- Determine workload hours needed by the RDN and/or CDM, CFPP and meet with administration for approval.
- A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required, so it's important to have clear communication and follow-up with any food and nutrition staff not present regarding diet order changes, referrals to RDNs, etc.

### Organizational Structure and Culture

- Review facility-specific care plan policies and procedures. Revise as needed and ensure all members of the IDT are knowledgeable about the processes.
- If a care plan software system is used, make sure the nutrition team knows how to use it and their assigned responsibilities.
- Review care plan format. It must be person-specific and include the date of the care plan, statement of the problem, measurable objectives, interventions, time frames to evaluate the resident's progress toward his/her goal(s), and assigned discipline(s) responsible for the intervention.
- Review management of the care plan meeting. Does everyone come prepared for the meeting? Is information on weights, current diet orders, preferences, etc. available? Is the meeting focused and is time managed efficiently?
- Support a culture in the IDT and throughout the facility that is person-centered with care plans that:
  - Promote growth and development
  - Focus on establishing and building relations
  - Understand that risk-taking is a normal part of life
  - Support continuous improvement in quality-of-care outcomes and resident satisfaction.

**IT IS IMPORTANT TO SELECT CARE PLAN TEAM MEMBERS** and assign responsibility and accountability.

## SUMMING IT UP

While regulatory or certification bodies may vary in care plan process requirements, it is always crucial to have a nutrition care plan. As a component of the overall care plan, the nutrition care plan should function as a living document for members of the healthcare team to provide person-centered "best practice" care.

It is the care plan process that provides communication for nutrition care between residents/patients and members of the interdisciplinary team, and provides a central focus of the agreed-upon healthcare interventions, goals, and outcomes.

Nutrition care planning that is incomplete or inadequate may have consequences that negatively impact the resident's quality of life, as well as the quality of care and services received. Nutrition leaders must clearly understand the care plan process and be actively involved in ensuring the nutrition care plan provides a central focus of the agreed-upon healthcare interventions, goals, and outcomes.

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# CE QUESTIONS | NUTRITION CONNECTION

This **Level I** article assumes that the reader has introductory knowledge of the topic. The desired outcome is to ensure a basic understanding and explanation of the concepts of the subject matter and recalling of related facts.

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1. Nutrition care plans should function as a _____ document for the healthcare team to provide person-centered and "best practice" care.
   A. Numbered
   B. Living
   C. Departmental
2. Regulatory noncompliance in development and/or implementation of the care plan was in the top 20 survey citations (as of 11/6/2022) in _____ healthcare settings.
   A. Acute, long-term care, and home health
   B. Pediatric clinics and geriatric clinics
   C. Home therapy and area health agency
3. A comprehensive care plan must describe _____ that are to be furnished to attain or maintain the highest practicable physical, mental, and psychosocial well-being requirements.
   A. Departments
   B. Documents
   C. Services
4. The care plan services provided or arranged by the facility must be _____-competent and _____-informed.
   A. Staff, nursing
   B. Departmental, supervisor
   C. Culturally, trauma
5. In long-term care, the interdisciplinary team (IDT) in care planning means that professional disciplines, as appropriate, will work together to provide the greatest benefit to the resident, and a member of the _____ staff is to participate.
   A. Corporate
   B. Food and nutrition services
   C. Resident council
6. The nutrition care plan team (CDM, CFPP; RDN; DTR) should clarify roles and responsibilities on the IDT that support appropriate _____ and state licensure.
   A. Scope of practice
   B. Staffing models
   C. Care plan models
7. Care plans should be person-centered and include the date of the care plan, statement of the problem(s), measurable objectives, interventions with time frames to evaluate progress toward goal(s), as well as the assigned discipline(s) _____ for the intervention.
   A. Present
   B. Responsible
   C. Monitored

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